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ABSTRACT

The report describes services, administration, and future directions of the Children's Special Health Care Services program, part of the Michigan Department of Public Health. Division programs are carried out at local, regional, and state levels and provide: preventive services (through generic and newborn screening services and neonatal intensive care programs); free diagnostic evaluations; medical care and treatment services (providing all or partial payment for hospital and outpatient care); locally-based services (community based support to chronically ill and handicapped children and their families); a specialized home care program (assistance to families caring for their children with complex needs at home); a parent participation project (parent peer support networks and parent feedback). Funding comes from state funds (51%), Medicaid (30%), and Child Health Block Grants (17%). More than 16,000 children were served during 1988-89 and an additional 12,000 children received diagnostic evaluations. Future directions are intended to: strengthen family-centered, community-based, coordinated care structures; implement methods to assure delivery of quality care; improve administrative and operational efficiency through better automated data systems; and increase responsiveness to the needs and concerns of families and providers. Appended are tables detailing numbers of children served and expenditures by locality and diagnosis. (DB)

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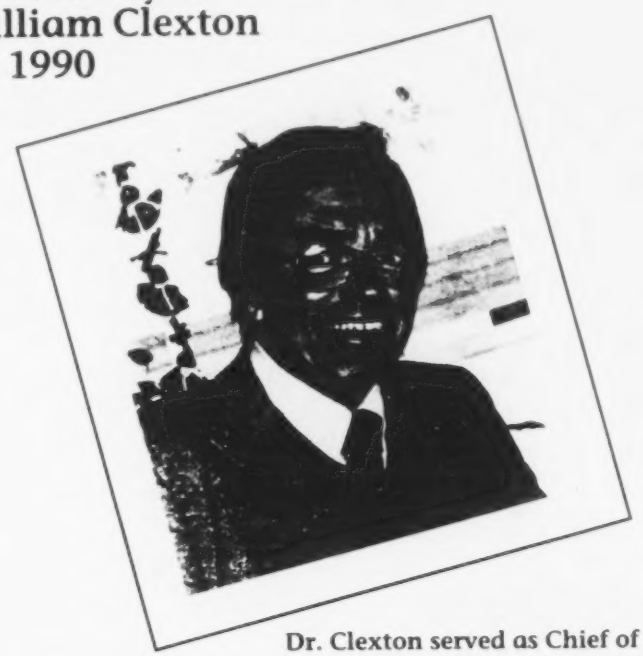
Michigan Department of Public Health

Division of Services to Crippled Children/Children's Special Health Care Services

TRIENNIAL REPORT 1986–1989

This publication is dedicated to the memory of Dr. William Clexton 1927 - 1990



Dr. Clexton served as Chief of the Division of Services to Crippled Children from 1982 to 1988. It is with appreciation and gratitude that we recognize his commitment to providing quality care and services for the children with special health care needs in Michigan.

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James J. Blanchard, Governor
Raj M Wiener, Director
Denise Holmes, Chief, Bureau of Community Services
Karen Schrock, Chief, DSCC/Children's Special Health Care Services

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES
TRIENNIAL REPORT

1986-87 1987-88 1988-89

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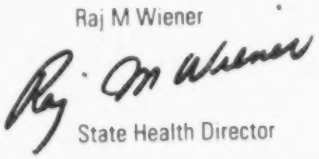
The State of Michigan historically has expressed a commitment to assist children with physically handicapping conditions or chronic illness. Optimal growth and development for all children who experience chronic illness or other physical handicaps continue to be the mission of Children's Special Health Care Services.

Consistent with national initiatives, the Division of Services to Crippled Children has been working to bring services into a more family-centered, community-based focus. Another goal is to eliminate physical, social, psychological and economic barriers to health care services for our families.

The Michigan Department of Public Health recognizes the significant role of hospitals, physicians and other medical and health care providers, local health department personnel, and other community agencies dedicated to providing care and services to these children and their families.

We provide this report with pride and gratitude to the Governor, the Legislature, and the citizens of Michigan.

Raj M Wiener



State Health Director

Executive Summary

Children with handicaps deserve every opportunity to develop to their maximum potential for health, education, self-support and self-fulfillment. This can occur when physical, social, economic and psychological barriers are eliminated to the extent possible, and full access to appropriate services is assured. Care should be family-centered, community-based and coordinated.

Children's Special Health Care Services (CSHCS) in the Michigan Department of Public Health demonstrates its commitment to this philosophy by providing:

PREVENTIVE SERVICES - through the Michigan Genetic and Newborn Screening Services Program and neonatal intensive care programs.

FREE DIAGNOSTIC EVALUATIONS - to children suspected of having handicapping conditions.

MEDICAL CARE AND TREATMENT SERVICES - annually providing all or partial payment for hospital care, outpatient treatment, medical supplies and equipment, prescriptions, services of physicians and other health professionals, and many other services to over 16,000 medically eligible, enrolled children.

LOCALLY-BASED SERVICES PROGRAM - community-based support through local health departments to chronically ill and handicapped children and their families by providing program representation, family assessment and case management.

SPECIALIZED HOME CARE PROGRAM - coordinated, comprehensive support to assist families in caring for their children with complex needs at home.

PARENT PARTICIPATION PROJECT - providing families a mechanism for input to CSHCS and establishing parent peer support networks.

Division programs are carried out at the local, regional and state levels.

New efforts during the past three years responded to the challenge of the Surgeon General of the United States to develop family-centered, community-based, coordinated care structures. As a result, the Specialized Home Care Program and the Parent Participation Project were developed and implemented. The Locally-Based Services Program was expanded to involve all 50 local health jurisdictions in Michigan.

Funding to support medical care and treatment came from State of Michigan Funds (51%), federal Title XIX Medicaid (30%) and Maternal and Child Health Block Grants (17%), and CSHCS Trust Fund donations and payment agreements. Expenditures were over $38 million in 1988-89. More than 16,000 children were served during 1988-89. In addition, 12,000 children receive diagnostic evaluations through CSHCS each year.

Future directions will: strengthen family-centered, community-based, coordinated care structures; implement methods to assure delivery of quality care; improve administrative and operational efficiency through better automated data systems; and increase responsiveness to the needs and concerns of families and providers.

Division of Services to Crippled Children

The Division of Services to Crippled Children (DSCC) is a division within the Bureau of Community Services (BCS) of the Michigan Department of Public Health. The Division administers Children's Special Health Care Services (CSHCS) and the Supplemental Security Income-Disabled Children's Program (SSI-DCP). In 1988 a new name, Children's Special Health Care Services, was given to the program to more accurately reflect the broad population served.

The philosophy of CSHCS is that children with handicaps or chronic illness have a right to develop to their maximum potential for health, education, self-support and fulfillment. CSHCS is committed to achieving this by: eliminating to the extent possible, all physical, social, emotional, and economic barriers; providing help and support to families; and assuring full access to appropriate services. Effort is made to develop service structures which promote family-centered, community-based, coordinated care.

From a parent.

"I am very thankful for the CSHCS Program. I can't imagine how stressful things would be if I had to try and pay alone all of my child's medical bills. Everyone that I have dealt with has been very kind, thoughtful, and informative in every situation."

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

The Michigan Public Health Code, Public Act 368 of 1978, states that to qualify for CSHCS, an individual must be under 21 years of age, reside in Michigan, have activity that is (or may become) so far restricted by physiological or structural defects as to reduce normal capacity, and have optimal potential that can benefit by specialized care. Persons over 21 with cystic fibrosis or hereditary coagulation defects (hemophilia) also may be eligible for services.

Enrollment in CSHCS involves determination of medical eligibility. A Regional Medical Consultant (a physician) is responsible for the consideration of several factors in this determination: type of condition; severity of the condition; and long-term effects of the condition on the child. Each case is evaluated individually, based on information documented in medical reports from providers.

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CSHCS covers chronic physical conditions that require care by medical or surgical specialists. The conditions include, but are not limited to, the following:

- amputation
- birth defects
- cerebral palsy
- cleft palate/cleft lip
- myelodysplasia
- certain visual disorders
- muscular dystrophy
- hemophilia
- certain heart conditions
- certain hearing disorders
- epilepsy and other neurologic disorders
- paralysis/spinal injuries
- cystic fibrosis/other chronic lung disease
- limb deformities
- neonatal disease
- immune deficiency disorders such as AIDS

From a parent

"The people I contact who work for CSHCS give very personal, careful, friendly, and even loving care and concern — it's like being in contact with a close family friend most of the time — this is our local office."

After medical eligibility is established, the family's financial resources are evaluated. Financial approval is automatic if the potential recipient is receiving Medicaid (Group I) or is a ward of the county, state or private child placement agency. For families not automatically eligible, the Michigan Public Health Code requires some families to share in the cost of their child's care through a payment agreement with the State of Michigan. The cost is determined according to an established payment schedule, based on gross income (minus five specific allowable expenses) and family size. These payment amounts may be adjusted if the family's financial situation changes during the eligibility period.

Both medical eligibility and financial participation are redetermined periodically by CSHCS.

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SUPPLEMENTAL SECURITY INCOME - DISABLED CHILDREN'S PROGRAM (SSI-DCP)

Supplemental Security Income (SSI) is a federal program of financial assistance for disabled or blind persons who have a low or moderate income, and who have a severe physical, mental, or emotional impairment. This income assistance program is administered by the Social Security Administration (SSA). The SSI-Disabled Children's Program (SSI-DCP) was created by Congress to assure that children eligible for SSI were given special assistance in securing the full range of services needed to attain economic independence as adults.

To be eligible for the SSI-DCP, a child must be under 16 years old, and have been determined eligible for SSI. Eligibility is based on family income and resources, and on evidence that the child has a physical, mental, or emotional impairment which significantly affects age-appropriate growth and development. Additionally, there must be evidence that the disability has lasted 12 months, or is expected to last 12 months, or will result in death. While financial eligibility is reviewed annually by the SSA, review of disability factors for continuing SSI eligibility depends on the nature of the impairment and the child's age.

The Disability Determination Service (DDS -the organizational unit within the Michigan Department of Education which makes disability determinations for SSI) notifies CSHCS of its decisions on all SSI applicants under age 16. These referrals are used for casefinding for CSHCS. All SSI-eligible children under age 16 are eligible for CSHCS Locally-Based Services.

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Servi e

Children with handicaps or chronic illness require comprehensive and coordinated services to address medical, psychosocial, developmental, rehabilitative and educational needs. There are many obstacles to the appropriate delivery of care to meet these wide-ranging concerns. The burden on these children and families includes financial stress, physical pain and/or discomfort, emotional stress, social stigma, and the frustrations of finding a consistent network of support.

Children's Special Health Care Services provides a range of services to children and their families. These services support the goals of prevention, early diagnosis, comprehensive assessment, medical care and treatment, and management of services to meet identified needs. Services are provided by a variety of health professionals in various settings, including inpatient and outpatient hospitals, specialty clinics, and in the home.

PREVENTION

CSHCS is involved at all levels of prevention: primary, the prevention of disease; secondary, the detection of disease before treatment is needed; and tertiary, treatment and rehabilitation to minimize disability from the condition. Examples of preventive services supported by the CSHCS include:

- genetic clinics for diagnosis, testing and counseling;
- newborn screening for specific conditions, e.g., phenylketonuria (PKU);
- scoliosis screening;
- neonatal intensive care programs in hospitals;
- locally-arranged otology clinics;
- habilitative and rehabilitative services.

CASEFINDING

CSHCS is required by law to locate and serve those persons under 21 in need of health services for handicapping or potentially handicapping conditions. Because many handicapping conditions progress rapidly, early detection is imperative in order to cure or lessen the effects. Early casefinding is effective and cost efficient since it allows for thorough evaluation and appropriate treatment planning.

The four major casefinding methods used by CSHCS are: the diagnostic referral system, field clinics, direct referrals and the SSI/Disabled Children Program.

Diagnostic referral system: Any child suspected of having a handicapping condition which would qualify him/her medically for CSHCS may have a diagnostic evaluation from a CSHCS-approved specialty clinic or pediatric specialist. Referral for these evaluations may be requested by contacting CSHCS Locally-Based Services (LBS) in local health departments.

Diagnostic evaluations are usually performed in outpatient specialty clinics located in over 60 Michigan hospitals which are approved for CSHCS diagnostic services. If a CSHCS-approved clinic is not within a 60 mile radius of the child's residence, a diagnostic evaluation may be authorized in a CSHCS-approved physician's office.

Results of diagnostic evaluations are forwarded by the clinic or physician to the CSHCS regional office, where a decision is made regarding medical eligibility for CSHCS.

Field clinics: CSHCS co-sponsors specialty clinics in order to provide expert diagnostic services in geographic areas where specialty medical service is not ordinarily available. Physician specialists from other areas of the state provide the medical services.

CSHCS also supports field clinics organized by the Hemophilia Foundation of Michigan and by MDPH and local health department hearing and speech staff. These clinics serve more than 7000 patients annually.

Enrollment in CSHCS is not required for participation in field clinics. These clinics are primarily diagnostic, and are available to any child under 21 years suspected of having a CSHCS-eligible condition. Medical information from a field clinic evaluation is forwarded to the CSHCS regional office for a decision regarding medical eligibility for CSHCS.

Direct referrals: A large number of children are already under the care of a physician when a handicapping condition is diagnosed, or when the family's circumstances change so that it needs assistance with the cost of medical care and treatment. A physician or hospital may make a direct referral to CSHCS.

SSI-Disabled Children's Program: As described earlier, the Disability Determination Service refers to CSHCS all disability decisions made for Supplemental Security Income (SSI) child applicants. While all children eligible for SSI are entitled to Medicaid and to Locally Based Services, the local health department reviews these referrals to determine if the child is also eligible for medical management by CSHCS. Referrals of children who are determined not medically eligible for SSI are reviewed by CSHCS Regional Medical Consultants to identify children who have a potentially CSHCS-eligible diagnosis and could benefit from CSHCS enrollment.

Any questions about CSHCS eligibility or enrollment may be referred to the local health department.

Samantha was born in the summer of 1988. Her parents were delighted that their first child was a healthy girl. Mother and daughter were home within a few days and both parents looked forward to showing off the newest member of the family. Before leaving the hospital, a small blood specimen from Samantha was obtained and sent to the Michigan Newborn Screening Program for testing. Samantha's newborn screen indicated an abnormal level of an important hormone which is necessary for proper childhood development. Her doctor was quickly notified of this result and confirmatory testing showed that she indeed had congenital hypothyroidism. By the age of 16 days Samantha had begun taking oral supplements of the hormone her body was not producing. Without such prompt diagnosis and treatment, children like Samantha suffer permanent growth and mental retardation. Since recognition of this diagnosis in Samantha, her parents have received counseling about how to manage the condition and Samantha is seen by a medical specialist who monitors her hormone treatment. She is growing and developing normally and her parents feel confident in their understanding of the continued medical care she will need. As her mother says, "Samantha is a real success story. We don't know what we would have done without the Newborn Screening Program."*

**Names have been changed*

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LOCALLY-BASED SERVICES (LBS)

CSHCS implemented Locally-Based Services (LBS) in recognition of the impact on the family when a child has special health care needs, and in response to families' needs for local assistance in gaining access to needed health care and other community resources. Through this program, local health departments serve as a community-based resource to assist families in accessing needed services, both from CSHCS and other service agencies in their communities. This is done via the LBS program components of program representation, family assessment and case management. These services are now available in each of the 50 local health departments covering all 83 Michigan counties. Families eligible for CSHCS and/or SSI-DCP are eligible for LBS.

One family can easily attest to the reassurance of having LBS support readily available during the long and stressful months of dealing with the ups and downs of their severely disabled child's condition - without forgetting the needs of their active healthy child.

From the time they came home from the hospital with their daughter who had multiple problems, notably microcephaly and the inability to regulate her temperature and almost-continuous seizures, the LBS nurse was their mainstay. Since the hospital was outside the state and not familiar with making referrals to CSHCS, the nurse actually initiated enrollment and continued to coordinate between the out-of-state clinic and in-state resources to get equipment and services. She also set up respite services, field clinic referrals, peer support with a family whose situation was similar and was a back-up for them in case of emergency. "If it wasn't for our LBS nurse, I don't know if I would have made it; anything we needed, she was right there - from helping us through the red tape to assisting in interactions with the physicians."

The nurse provided their other child with age-appropriate reading material on having a handicapped sibling and on death, and always had a kind word or a little treat for him. She happened to be there when the baby died unexpectedly and made all the necessary calls. Because of her knowledge of the grieving process, she facilitated the family's acceptance by encouraging them to spend some time holding their dead child. "We have genuine respect and love for her."

Program Representation

Program Representation refers to activities which promote and publicize the services provided by CSHCS so that individuals in need become aware of their availability. The goals are to identify and enroll CSHCS-eligible children and assure that the community and participants are informed about the program.

Program representation activities include:

- Education of enrolled families, providers and the community, to increase awareness and understanding of CSHCS services;
- Coordination with agencies serving the handicapped population to achieve efficient casefinding, referral and service delivery to eligible children;
- Assuring that medical evaluations are conducted on potentially handicapped children so that CSHCS medical eligibility may be determined;
- Public relations to increase visibility, support, and participation in programs serving handicapped children;
- Assisting families to resolve processing and procedural problems and questions.

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Family Assessment for Service Needs

At certain times parents may need considerable support to manage their child's special health care needs and maintain family stability. The policy of family assessment is based on the recognition that the family is a group and the child's disability affects other family members. During family assessment, local health department professionals assist in identifying the needs of all family members. Potential problem areas might be financial, social/emotional, physical/health care, developmental, and educational/vocational. Assistance is given to identify options and resources for intervention, and to initiate services if needed.

The number of cases referred to local health departments for family assessment continues to grow each year, as reflected below:

	1986-87	1987-88	1988-89
Cases referred	17,490	18,548	20,622
Referrals completed	12,938	13,076	15,038

The numbers indicated as "Referrals Completed" reflect that a contact has been made by the local health department to the family and the referral process completed. Most of these families receive an assessment; however, some families decline service, move from the state or area, or are no longer in need of assistance.

Case Management

Case management helps families gain skills and independence in problem solving, management of the human services system and self advocacy. Problems typically confronting the family of a child with special health care needs include: 1) accessing services; 2) providing daily care; 3) meeting costs of care; and 4) maintaining stability in the family unit. These can at times become overwhelming demands for the family. Professional assistance to help families manage their identified needs promotes optimal growth and development for each family member.

The need for case management services is determined during a family assessment. In addition to a concurrence by LBS staff and the family that there is a need for case management services, the family must also desire this kind of assistance. Since the inception of LBS, approximately 15% of the families assessed have also received case management assistance each year.

Case management activities include:

- Clarifying the goals of planned intervention;
- Providing the family with information about available care options and services, service rights and entitlements;
- Preparing the family for referrals to appropriate resources;
- Coordinating services, establishing common goals, and identifying responsibilities for the provision of specified services;
- Representing the family in negotiations to obtain necessary services by appropriate providers;
- Assisting the family to develop skills in identifying problems, exploring alternatives, and making decisions.

The local health department professional will discuss with the family whether all of its case management needs are being met. Together, they will decide whether CSHCS case management is needed. If another agency is already providing equivalent services, it may be advantageous for it to continue full responsibility for this; joint case management by the other agency and CSHCS may also be considered.

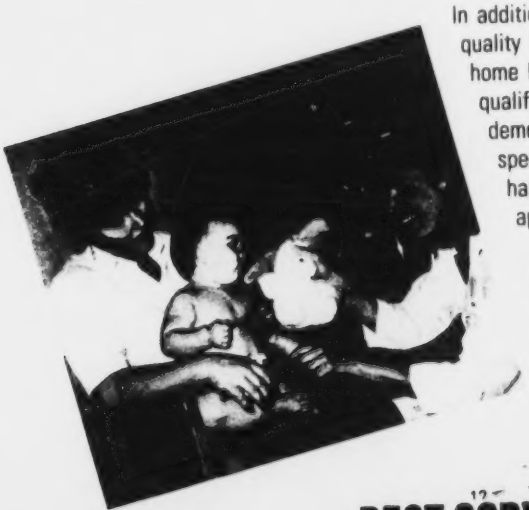
The following chart shows the number of families provided each of the options for case management during fiscal years 1987, 1988 and 1989.

	1986-87 Number	1987-88 Number	1988-89 Number
Total Families in Case Management	1,695	1,328	1,032
LBS Only	991	785	550
Other Agencies Only	509	393	344
Combined LBS and Other Agencies	195	150	138

MEDICAL CARE AND TREATMENT

A major component of Division services is the authorization and payment for medical care and treatment. In a historical sense, this has been the central focus of CSHCS services and continues to be the largest segment of the budget. Recognition of the importance of other supportive services in the past decade has broadened the Division's approach to services; however, medical care and treatment continues as a core service which is highly valued by the children and families served by the program.

Medical care and treatment includes a wide range of services such as physician care, hospitalization, special therapies and equipment, home health nursing, and orthotics/prosthetics.



In addition to making payments for these services, CSHCS assures quality in the services provided. Physicians, hospitals, clinics and home health agencies must meet established criteria in order to qualify as "approved" providers. These criteria are focused on the demonstration of expertise and willingness to provide pediatric specialty services. Along with the approval of providers, each child has specific providers authorized so that specialty expertise is appropriate for the child's condition.

Many of the charts and tables in the Appendix provide more detailed information on how medical care and treatment dollars have been spent.

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SPECIALIZED HOME CARE PROGRAM (SHCP)

One outcome of the technological advances of the past decade is a dramatic increase in the survival rate and longevity of children with complex care needs. Historically, these medically fragile children have been cared for in hospitals and other medical institutions.

Family-centered care is a viable reality for children with even the most extensive needs, but it requires the provision of intensive service supports. Home placement is often considered advantageous from a number of perspectives, including quality of life for the child and integration and cohesion of the family unit. Home and community placement is also consistent with several state and federal policy initiatives focusing on deinstitutionalization and improving opportunities for family-centered, community-based, coordinated care.

In order for home care to be successful, a broad spectrum of health and supportive services must be arranged, including health care, social supports, financial support, and educational and vocational assistance. While medical equipment and supplies and hourly nursing care are typically the major (and most costly) services required, a coordinated approach to this comprehensive array of services, with the family's involvement, is essential.

The Specialized Home Care Program (SHCP) was developed within CSHCS, in collaboration with Medicaid, to respond to the needs of technology-dependent children and their families. It assists families by providing publicly-funded, coordinated home care for children with chronic illnesses which impose exceptional demands on the family. Both the medical needs of the child and the support needs of the family are taken into consideration when developing a plan of care. While families are the primary caregivers for their children, they are assured the availability of supportive services.

A critical feature of the program is specialized care management. This comprehensive and coordinated process facilitates planning for care at home and for the transition of care from a medical facility to the home community. It also assists with stabilization of care and services within the family home, and arranges for ongoing management of services by the family and community resources.

Since the availability of services and service providers changes frequently, it is the family that is the constant in the child's life, and has the pivotal role in the care of the child. Therefore, care for the child involves goals directed toward increasing family capability, effectiveness, and control.

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Cathy was born in 1986 with several medical problems which make her care outside the hospital difficult. She requires an apnea monitor and careful monitoring of her fluid levels and weight, and she is oxygen dependent. When discharged, she would be home only four or five days before being rushed back to the hospital in severe respiratory distress. These recurring hospitalizations were very stressful for all family members and the hospital administration began to question Cathy's "revolving door" care plan. Cathy's physician was presented with a dilemma. He believed in home-based care, but he was not sure it was feasible for Cathy.*

A referral was made to the SHCP for "specialized" assistance with discharge planning, home care coordination, and payment for in-home services. With support from the program, Cathy was home eight weeks without a re-hospitalization. By then, everyone involved in her care was optimistic that home care really could work for her.

Now, 16 months later, Cathy is doing beautifully at home. She still requires complex care and is intermittently hospitalized for respiratory infections, but those are fewer in number and shorter. Special protocols have been developed for monitoring and adjusting oxygen levels and for maintaining fluid levels, and 11 hours per day of nursing care are authorized. Cathy is beginning to talk and to feed herself, and to crawl and stand. Although she has no vision, she can find toys where she last played with them. This ability demonstrates she may not be as intellectually impaired as first thought. She attends a school-based program part-time and receives early intervention services at home. Both Cathy's health status and the community-based service system have stabilized to the extent that "specialized" care management is no longer needed. The SHCP continues to fund her home care, to conduct quality assurance review, and to provide support for managed care by the local health department.

Services are cost-efficient. Cathy's care at home costs $32,396 less per year than care in a hospital. More importantly, Cathy is doing well, and her family is benefitting from a stable service system with few hospitalizations. The lives of Cathy and her family have been enriched by the opportunity for care at home.

**Names have been changed.*

PARENT PARTICIPATION PROJECT (PPP)

CSHCS's latest effort to ensure a family-centered, community-based, coordinated service system is the development of the Parent Participation Project. A parent of a special needs child was hired to coordinate this effort. This informational and support network is designed to assist parents in managing the demands placed on them as a result of their child's special health care needs. One element of the PPP is the Family Support Network, a coordinated network of parents and parent support groups, across disabilities. Another important component of the PPP is the incorporation of parental input into CSHCS program and policy development. The driving principle in every PPP activity is the facilitation of parent/professional collaboration at all levels of health care.

Michigan's PPP is unique in that it is not only cross-disability, but it is community-based and is very much a collaborative effort with local health departments. The result of this system will be a statewide coalition of parents who have children with all kinds of disabilities, who are active collaborators with health professionals, and who are partners in developing those programs and policies which have a significant impact on the services provided for families.

From a parent . . .

"As far as support groups are concerned, we personally are receiving very good emotional support from our families and friends and church, but occasionally talking to another family going through what we have would have been nice. Also, we are now emotionally equipped to talk with other families."

One of the most important aspects of the Parent Participation Project is the opportunity for parents to meet other parents who are in similar situations. The benefits are tremendous and usually intangible.

Karen Rogers, whose son Jason* was diagnosed with a severely disabling neurological disorder at the age of 2-1/2 years puts it this way:*
"The most important gift that was given to me by another parent was the permission to laugh, permission to enjoy life even though I had a sick kid. I thought that because I had all this responsibility with my son, how dare I laugh? Thanks to people I met through the Parent Participation Project, I could be normal again because, to me, being normal means being able to laugh. I knew that it was OK not to be serious all the time. I could have good days and bad days - I didn't have to walk around with my hands folded and my head down."

** names have been changed*

GENETIC AND NEWBORN SCREENING SERVICES PROGRAM

Each year, over 6,000 Michigan infants are born with serious birth defects or other genetic disorders. The purpose of this CSHCS program is to assure the availability of diagnostic and counseling services for these children and their families through a network of genetic centers and outreach clinics located throughout the state. Clinic visits provide information about a specific diagnosis, discussion about the prognosis and natural history of the condition, explanation of the mode of inheritance, and exploration of health management or reproductive issues. Many parents report that discussion with the geneticist or genetic counselor helps them to better understand their child's disorder and how to maximize his or her development.

Since 1987 all Michigan newborns have been screened for six relatively rare, but treatable, conditions: phenylketonuria (PKU), congenital hypothyroidism, galactosemia, biotinidase deficiency, maple syrup urine disease (MSUD) and sickle cell anemia. The Newborn Screening Program each year identifies and diagnoses approximately 160 infants with one of the six genetic disorders. This important program not only prevents mental retardation, illness and death, but has proven to be cost effective as well. For example, for congenital hypothyroidism, each dollar spent on screening saves $5 on treatment after one year. In one year, savings to the state amount to almost $3.5 million, and in ten years, savings would amount to over $190 million. Since comprehensive newborn screening follow-up was instituted in 1987, the number of diagnosed cases of hypothyroidism in Michigan has doubled.

Another component of the Division's program includes sickle cell testing and counseling, which are offered in ten Michigan communities with significant numbers of Blacks. In 1989, support services such as education, social work and medical management were provided for 529 individuals with sickle cell anemia.

Genetics education for health care professionals, educators, and parents is also an important part of the program. Continued progress in diagnosis, management and prevention of genetic disorders requires that the public be provided with information on the implications of these advances for their health care and reproductive decision making. Projects such as a genetics newsletter, speakers' bureau and teacher workshops help to keep professionals and consumers aware of relevant changes in the causes and prevention of birth defects and genetic disease. A Genetic Advisory Committee, with representation from health care professionals, consumer groups and genetic center staff, meets regularly to provide oversight and make recommendations to MDPH about genetic services in Michigan.

QUALITY ASSURANCE

The Division continues to place high priority on improving and maintaining high quality care for the children it serves. A major quality assurance effort has been the development of guidelines for care of children with certain specific conditions. Multidisciplinary committees of experts who provide care to these children have been convened by CSHCS to develop the guidelines. These describe not only the specific kinds of care to be delivered by various professionals, but also the expected patient outcomes. So far, guidelines for care of persons with myelodysplasia have been completed; guidelines for care of oral cleft patients are currently under development. Other conditions will be the focus of future activity.

Another major quality assurance effort has been improving the provider approval system. By establishing CSHCS provider eligibility criteria which approve only those providers who are qualified and experienced in the delivery of services to special needs children, the quality of care can be improved.

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Program Administration

CSHCS activities occur at three distinct but interrelated levels: central office, regional offices, and local health departments.

CENTRAL OFFICE

The CSHCS central office provides overall executive direction and program administration for the Division. Functions include policy analysis and development, program and fiscal management, and professional consultation.

Policy analysis and development set the basic philosophical direction for the program. Policies are based on providing services in the most effective and efficient manner possible. This process also looks at needs which are not being met and plans for ways to meet these needs.

Program and fiscal management utilizes data systems to identify and enroll children, and to pay for their medical care and treatment. Through an agreement with the Michigan Department of Social Services, the Medical Services Administration serves as fiscal agent and pays providers for CSHCS medical care and treatment services through its Invoice Processing System.

Professional medical, nursing, nutrition, and speech and audiology consultant services are provided to a wide array of individuals and groups. The consultants' services are dedicated to improving the quality of care for children with disabilities. This involves writing guidelines for the care of specific conditions, providing training and technical assistance to providers, and advocating for improved service coordination among state agencies and specialty care providers.

REGIONAL OFFICES

Regional offices located in Detroit, Grand Rapids, Lansing, Marquette and Pontiac serve as the primary point in organizing the delivery of services for children and families. They are responsible for: approving medical eligibility; authorizing providers; determining prior approval for certain services; maintaining case records; and communicating with providers, local health departments and other agencies.

Regional offices are directly involved in providing in-service training and monitoring service delivery. The consultation role of regional offices includes technical assistance to local health departments to enhance the quality of family assessment and case management services. The map on page 32 indicates the CSHCS regional offices and the counties each services.

LOCAL HEALTH DEPARTMENTS

Program services are provided by public health nurses and paraprofessional staff, known as Locally-Based Services (LBS) Representatives. In addition, each local health department designates a senior level Public Health Nurse as its LBS Coordinator to oversee program implementation and be the primary contact between the local health department and the CSHCS central and regional offices. A description of LBS in local health departments is on page 10.

From a parent.

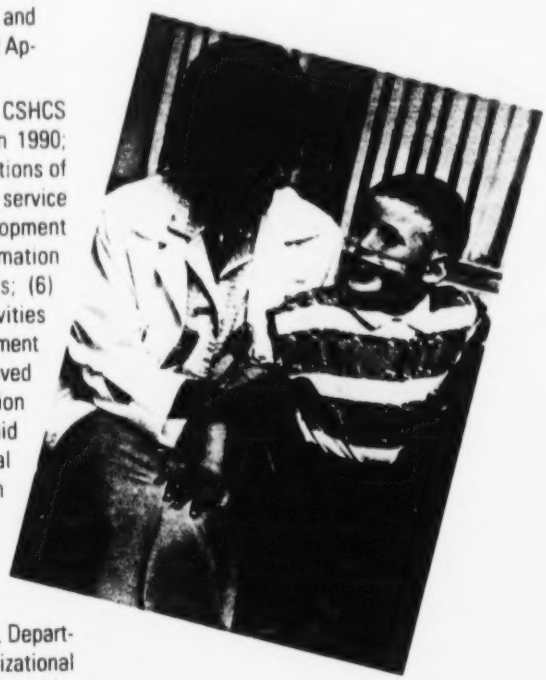
"I am very satisfied with CSHCS and the people who work with me on it. I consider this a real lifesaver because I could not afford needed medical treatment otherwise. As far as emotional support is concerned, my physical problem prevents me from working and it seems the general public doesn't really understand why some people can't work and why it is difficult to keep up with financial obligations."

ADMINISTRATIVE PRIORITIES

CSHCS has been involved in a major initiative to automate and streamline certain program responsibilities related to service delivery. The purpose of these changes is to improve the quality of care and make the system more responsive to families. To accomplish this, CSHCS has established three major priorities for fiscal year 89/90. They are:

1. Beginning the implementation of a new CSHCS Information System;
2. Development of a complete Provider Approval Process; and
3. Development and implementation of a complete Client Appeals Process.

Other administrative initiatives include: (1) creation of a CSHCS advisory committee, scheduled to hold its first meeting in 1990; (2) reorganization of the CSHCS to better integrate the functions of the local health departments and CSHCS; (3) integration of service delivery functions within local health departments; (4) development of a policy and procedure system; (5) improved public information materials describing CSHCS to families and providers; (6) establishment of a system for monitoring and tracking activities at the LHD, regional and state levels; (7) facilitating the development of professional guidelines for care of CSHCS children; (8) improved relationships between the Medical Services Administration and CSHCS, including improved access and use of the Medicaid Management Information System (MMIS); and (9) several new monitoring components to better analyze and report on the expenditure of medical care and treatment funds.



CSHCS Information System

In 1985 the Office of Management and Information Systems, Department of Management and Budget, began a review of the organizational and operational activities of the DSCC. This project, known as the Management Improvement Project (MIP), was completed in 1987.

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From a parent

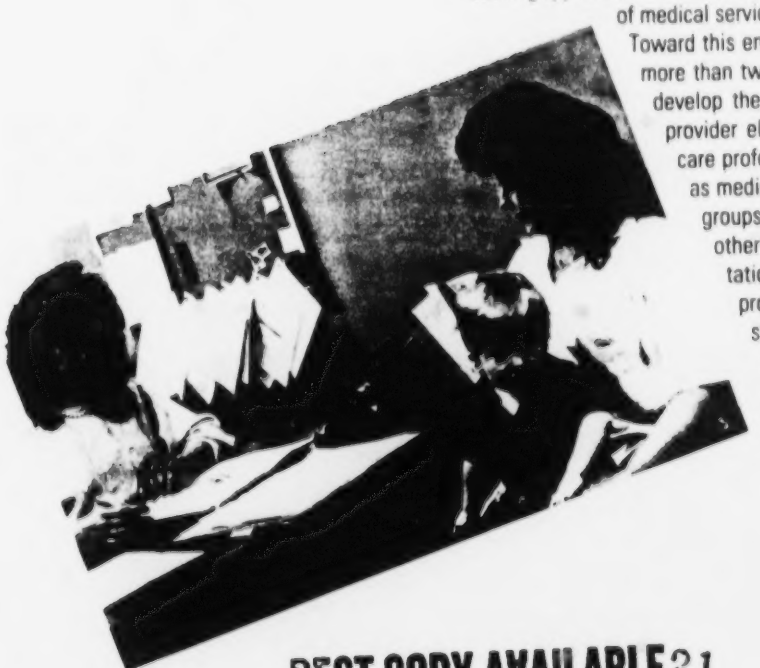
"Without the medical coverage CSHCS provides, we would be in debt for the rest of our lives. One of my daughter's medicines is expected to cost almost $30,000 a year by the time she's in high school."

The MIP report recommended that action be taken to streamline and automate the three major CSHCS information systems: 1) eligibility determination/client processing, 2) prior authorization, and 3) claims processing. The consulting firm of KPMG Peat Marwick was contracted to develop System Requirements Definition, System Design Objectives, System External Specifications, and a detailed Implementation Plan. In October, 1989, these products were delivered and accepted by the Department.

Another request for proposal (RFP) will be developed to implement the project. The system proposed will be an online system that has ten major systems functions. These functions are case finding, family assessment, LHD service delivery, medical eligibility determination, case processing, prior authorization, claims operations, reference tables, management information and reporting and case activity logging.

Provider Approval Process

With the caseload of CSHCS increasing, and with more providers seeking approval, the need for a structured process for assuring quality of medical service to children has become apparent. Toward this end, CSHCS organized a task force of more than two dozen statewide organizations to develop the policies and procedures by which provider eligibility is determined. Key health care professionals were represented, as well as medical schools, hospitals and consumer groups. Joining them were consultants from other governmental, licensing and accreditation bodies. The CSHCS Provider Approval Task Force, some 70 members strong, gathered for several day-long meetings, over a two month period, to complete its mission.



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The result is a recommended system of criteria, measures and methods for assessment of the qualifications of physician, hospital, clinic and home health agency providers. A significant feature of the system is its recognition of levels of specialization among providers for purposes of approval, prior authorization, review and monitoring. The distinguishing thread lacing all of the system's components together is its emphasis on criteria which promote family access to care, family involvement in care, and the coordination of care for the benefit of families.

Client Appeals Process

Without an established process for review of decisions about eligibility, benefits and financial assessment, the response to client disputes can be inconsistent and unreasonably delayed. The CSHCS commitment to family-centered care brought attention to this situation and to the development, in late 1989, of an Appeals Policy and Procedure System for program clients. The process provides families an opportunity to "appeal" decisions which they feel are inconsistent with established rules or guidelines governing the program. Embodying generally accepted principles of equity, the system established the following client rights:

- To receive notice of all case actions affecting eligibility. This includes an explanation of the right to appeal, how to file an appeal request, and the right to designate an authorized representative to assist the client throughout the appeal process.

- To have the current payment agreement and level of service maintained, pending resolution of the dispute if the request for appeal is filed within ten working days of the notice of action.

- To request an appeal within 60 working days of CSHCS notice of action related to any of the following:
  - Denial of eligibility.
  - Reduction in amount of program benefits or service.
  - Denial of program benefits or service.
  - Termination of program benefits or service.
  - Restrictions under which assistance or service is provided.
  - Level of financial participation.
  - CSHCS action delayed beyond standards of promptness.

- To review the case file, except that to which the client is not entitled by law, and to secure copies of needed documents.

- To receive the final decision and order within 30 days of filing the request for appeal.

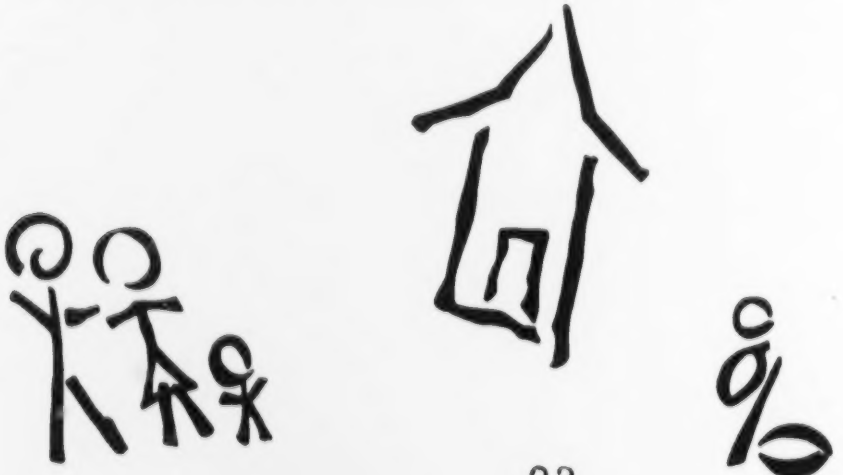
- To appeal a final CSHCS decision to the Chief of the Bureau of Community Services.

Coordination with Other Programs, Agencies and Organizations

For many children with special health needs, a broad spectrum of services must be arranged, including medical and health services, social and emotional supports for the child and family, educational and vocational assistance, and financial assistance. CSHCS engages in a variety of activities with other organizations, agencies and programs to coordinate efforts directed toward children with special health needs and their families.

These activities are carried out by staff at the local, regional and central levels of CSHCS. Examples of categories of activities include: individual case conferences to develop a coordinated plan for community-based care; serving on committees of professional and voluntary associations concerned with children's health care; professional consultation to other public agencies' direct service staff, in selected specialty areas; inter- and intra-departmental planning and policy initiatives; responding to requests to participate in task forces, work groups, committees, and advisory councils which address, directly or indirectly, issues of children's health; working with demonstration projects to improve care and services to children with specific health problems, such as AIDS; and inviting representatives of other agencies and organizations to participate in CSHCS activities which may affect their programs, policies, or financing mechanisms.

While the specific focus for collaborative efforts evolves in response to emerging needs, the goal of all activities is an enhanced capacity to address a wide range of policy issues, service needs, and financing dilemmas. Specific examples of recent efforts include: working with the Michigan Department of Education and with Medicaid to coordinate medical and health related services to children receiving these services from CSHCS and local or intermediate school districts; working with the Department of Mental Health and with Medicaid to identify and resolve barriers to home and community-based care for children who would otherwise require care in a medical facility; working with the Departments of Social Services and Mental Health, with the State Planning Council for Developmental Disabilities, with Michigan Protection and Advocacy, and with parents to develop a formal proposal for inter-agency planning for children with extensive health and medical needs; supporting the Maternal Infant Center for HIV (MICH), a three-year demonstration project for pediatric AIDS prevention and control; and the involvement of representatives of government agencies, provider associations, and consumers in the process to develop recommendations for CSHCS approval of hospitals, physicians, clinics, and home health agencies.



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Sources

Several sources of funds support the work of CSHCS. The State of Michigan is the major funding source, followed by the federal government, private donations, and family participation in payment agreements to reimburse the state.

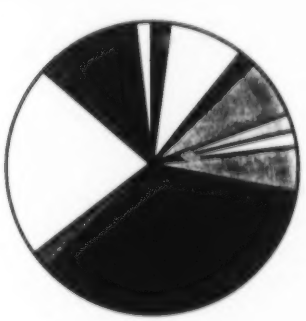
The chart below shows the proportionate sources of funding for fiscal years 1986-87, 1987-88, and 1988-89.

- General Fund (State) (51.2%)
- Title XIX (Federal) (29.7%)
- Title V (Federal) (16.9%)
- Private Bequests (1.1%)
- Fees & Collections (1.1%)

Federal funds for the program are received through the Maternal and Child Health Block Grant. Title V of the Social Security Act of 1935 historically has provided funds to each state for children's special health care services. Medicaid (Title XIX) funds are designated for payment of medical care for handicapped children eligible for both Medicaid and CSHCS.

Expenditures

The chart below displays expenditures for medical care and treatment of enrolled individuals, by diagnosis, for fiscal years 1986-87, 1987-88 and 1988-89. Tables in the Appendix provide detailed data on these expenditures.



- Respiratory (1.9%)
- Cancer (8.3%)
- All Other Codes (1.9%)
- Metabolic (7.0%)
- Circulatory (1.8%)
- Genitourinary (1.8%)
- Blood (5.0)
- Over Age 21 (4.3%)
- Congenital Anomalies (30.9%)
- Musculosketetal (1.7%)
- Nervous System (21.6%)
- Injury and Poison (1.9%)
- Ill-Defined Conditions (2.0%)
- Newborn (9.6%)

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Trust Fund

Jeremy has leukemia and comes to the Michigan State University Clinical Center ambulatory clinic for care. The medical procedures he receives can sometimes be very painful. Because he knows how uncomfortable these therapies can be, Jeremy often becomes anxious and depressed just before his clinic appointment. This apprehension may compound his medical problems and actually intensify the pain.*

Thanks to funding from the CSHCS Trust Fund, some research has been occurring at the MSU Clinical Center to help patients like Jeremy manage their pain. Techniques using behavioral therapy and hypnoimagery help children focus on other things and not feel the same levels of discomfort. The procedures being developed at the MSU Clinical Center are not only helping the children undergoing therapies at that location, but also serving as an educational model to teach health professionals throughout Michigan similar techniques that will enable children to more comfortably undergo the lifesaving treatments they need.

**Names have been changed.*

The CSHCS Trust Fund is a separate source of funds consisting of money, property, stocks, securities and other items of value which have been donated by private individuals to CSHCS. The fund was started in 1944 through a bequest by Dr. and Mrs. Ralph Pardee, whose gift continues to comprise a major portion of the Trust Fund resources. The intent of these contributions is to support unique services and projects outside the traditional scope of program services beyond that provided by general State fund appropriations. Among the recent expenditures from the Trust Fund have been special equipment for which there is no other payment source, support of conferences on special issues for health care professionals, and research efforts which will improve the types and quality of care for handicapping conditions.

Receipt of money for the Trust Fund is authorized by the Public Health Code. The Division is always grateful to receive contributions from private individuals and groups in order to assist with these unique needs. The inside of back cover lists the names of Trust Fund donors from January through September, 1989. Sincere thanks and appreciation are extended to all past and future Trust Fund contributors.

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Future Directions

There are many exciting opportunities for growth and change which Children's Special Health Care Services plans to explore and develop. All of these emanate from the same central challenge, to implement family-centered, community-based, coordinated care. Any opportunity for change will be measured by whether it improved the ability of CSHCS to meet this challenge.

A prerequisite for implementing family-centered, community-based, coordinated care is dialogue with the families of children with special health care needs and the providers of direct services. To enhance this interaction, CSHCS is planning to expand the Parent Participation Project, with the ultimate goal of a statewide structure. In the near future an Advisory Committee will be formed to broadly represent all parties affected by CSHCS, with particular emphasis on parents and providers. Finally, building formal structures for communication with provider groups is another important objective of the Division.

Many of the administrative initiatives of the Division previously referenced have the goal of improving responsiveness to families, both in terms of speed and accuracy of that response. The systems project is the largest effort of this type. Improved automated data processing will have payoffs in terms of efficiency and better access to information. This should shorten the amount of time needed to enroll a child or provider in the system and enable Division personnel to reply more quickly to inquiries. Other administrative projects will focus on the review and documentation of policy with key areas being eligibility and covered services. It is expected that this will improve consistency in decision making.

A unique resource to CSHCS for many years has been the Trust Fund. Many individuals and organizations have made contributions even though there has been little publicity or promotion. CSHCS plans to take steps to broaden public awareness of the CSHCS Trust Fund and the many special services and projects which have been supported with these funds.

This look forward would not be complete without inclusion of the unique needs of technology-dependent, medically fragile children and their families. The Specialized Home Care Program was developed to address these unique needs and has made an important contribution, but it certainly has not provided all the answers. The Division will be working on those problems which have not yet been resolved.

Clearly, this is an abbreviated summary of what the future holds. Many of the initiatives described broadly address the needs and problems of the children and families served. However, as the Specialized Home Care Program targets a very narrow and complex population, CSHCS is dedicated to solving both large and small problems in order to help improve the lives of children and families.

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TABLE I

BY COUNTY OF RESIDENCE, THE CASES AND EXPENDITURES* FOR MEDICAL CARE AND TREATMENT PROVIDED CHILDREN

County	Children Provided Treatment 09/30/87	09/30/88	09/30/89	Expenditures for Care and Treatment 09/30/87	09/30/88	09/30/89
TOTALS	**15,628**	**16,272**	**16,551**	**$27,876,957.41**	**$29,110,311.91**	**$34,520,194.44**
Alcona	19	24	24	31,339.56	62,468.57	34,633.50
Alger	28	27	22	23,270.30	34,393.73	29,200.24
Allegan	164	194	210	329,111.32	380,846.31	515,543.30
Alpena	114	109	92	111,125.96	83,019.09	90,566.05
Antrim	56	50	58	107,784.48	54,004.14	78,384.64
Arenac	54	57	53	115,112.55	131,346.49	144,426.60
Baraga	16	20	19	30,065.29	17,986.92	16,188.93
Barry	108	119	118	192,518.49	174,547.73	328,858.48
Bay	201	225	202	269,770.11	324,774.95	316,618.22
Benzie	42	32	32	53,723.04	55,949.48	138,654.39
Berrien	265	300	321	581,544.46	534,628.44	593,478.64
Branch	104	105	117	182,087.00	273,215.49	186,823.14
Calhoun	264	253	292	613,035.98	561,801.05	487,980.39
Cass	67	72	71	119,101.51	103,171.07	195,753.80
Charlevoix	73	75	66	187,862.52	165,815.55	106,065.30
Cheboygan	94	108	122	217,997.64	189,149.44	175,982.48
Chippewa	58	72	84	85,946.34	83,293.70	134,412.71
Clare	91	96	87	135,208.94	196,030.32	162,637.67
Clinton	133	147	129	207,673.84	258,084.57	206,015.68
Crawford	49	41	43	116,600.94	95,616.26	85,478.77
Delta	103	102	103	135,075.76	106,130.42	187,345.76
Dickinson	26	29	37	23,522.21	16,755.43	23,869.85
Eaton	183	202	209	228,831.41	246,217.59	294,490.66
Emmet	106	105	88	162,488.07	136,479.74	175,197.61
Genesee	593	676	684	1,293,661.70	1,424,316.83	1,732,879.87
Gladwin	55	57	51	260,314.68	143,930.85	253,846.70
Gogebic	21	22	25	72,541.65	16,453.74	30,035.58
Grand Traverse	273	248	250	351,481.73	267,409.26	353,705.88
Gratiot	115	120	108	240,119.07	249,925.10	188,216.16
Hillsdale	127	129	121	542,160.47	298,497.68	427,215.41
Houghton	100	125	127	84,098.17	125,443.88	120,496.83
Huron	152	167	179	104,129.91	166,269.92	255,276.64
Ingham	684	695	719	986,944.83	1,168,498.68	1,712,925.93
Ionia	130	135	132	126,939.07	200,325.52	267,632.97
Iosco	95	109	105	120,208.94	118,773.37	89,077.92
Iron	28	29	32	30,047.11	48,333.81	21,653.91
Isabella	125	126	113	163,581.56	124,854.61	131,166.83
Jackson	366	384	372	688,345.23	804,181.32	837,547.43
Kalamazoo	314	336	354	564,162.83	684,315.55	757,454.76
Kalkaska	75	65	62	118,495.29	173,339.71	69,856.11
Kent	894	900	916	1,773,332.39	1,447,084.26	1,487,620.71
Keweenaw	3	4	3	1,524.91	2,697.92	2,140.83

*Including only those processed through the automated payment system.

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TABLE I (continued)

BY COUNTY OF RESIDENCE, THE CASES AND EXPENDITURES* FOR MEDICAL CARE AND TREATMENT PROVIDED CHILDREN

County	Children Provided Treatment			Expenditures for Care and Treatment		
	09/30/87	09/30/88	09/30/89	09/30/87	09/30/88	09/30/89
Lake	23	21	23	$ 20,032.34	$ 20,523.00	$ 24,101.13
Lapeer	134	158	167	282,099.84	273,560.70	202,993.26
Leelanau	43	42	41	91,554.60	35,292.41	93,379.39
Lenawee	182	195	178	300,639.00	422,162.33	457,706.10
Livingston	190	195	177	420,238.60	344,612.02	400,391.59
Luce	19	23	23	24,891.67	42,818.66	27,282.66
Mackinac	23	28	29	38,163.25	44,764.03	56,514.95
Macomb	715	687	725	1,422,106.20	1,394,098.13	1,523,658.59
Manistee	45	45	49	58,266.87	43,713.23	79,543.65
Marquette	182	189	171	210,217.34	330,596.27	183,020.71
Mason	59	40	40	81,538.30	61,728.30	31,101.56
Mecosta	101	108	116	144,670.40	235,492.86	326,848.82
Menominee	54	53	38	84,229.40	42,564.56	79,630.48
Midland	143	165	169	237,987.00	250,327.73	278,870.25
Missaukee	60	57	57	69,315.09	60,863.98	34,572.91
Monroe	241	257	269	360,593.23	408,394.42	534,255.73
Montcalm	141	152	174	129,547.49	107,672.26	178,077.80
Montmorency	35	33	34	23,854.27	44,964.01	24,879.08
Muskegon	287	293	311	423,325.87	466,768.93	484,652.04
Newaygo	72	72	77	92,105.08	63,596.21	121,175.14
Oakland	1,069	1,118	1,103	1,599,682.02	2,053,202.94	2,365,066.73
Oceana	31	33	40	104,662.99	51,782.66	60,186.30
Ogemaw	53	55	46	91,262.09	84,726.41	67,170.28
Ontonagon	21	27	26	15,155.26	31,106.85	26,328.64
Osceola	127	125	112	155,392.25	99,846.49	115,420.33
Oscoda	28	33	29	37,817.98	34,008.31	59,994.86
Otsego	69	70	59	117,073.04	76,342.43	161,650.44
Ottawa	292	296	297	460,707.34	651,565.70	443,230.97
Presque Isle	51	51	42	133,659.79	68,172.76	89,068.07
Roscommon	48	47	41	79,627.24	82,648.25	54,591.68
Saginaw	383	382	367	625,450.82	666,964.93	682,937.42
St. Clair	379	413	410	503,763.01	615,383.24	583,569.31
St. Joseph	142	149	144	160,297.15	159,853.00	184,098.94
Sanilac	133	157	149	176,943.23	150,879.00	180,184.01
Schoolcraft	32	36	31	47,511.10	112,528.59	41,572.33
Shiawassee	203	183	179	214,016.45	229,639.58	197,239.21
Tuscola	216	227	260	267,271.38	209,935.22	375,411.43
Van Buren	180	185	195	413,823.75	328,692.23	400,677.72
Washtenaw	324	330	342	652,414.75	842,741.83	910,119.18
Wayne	1,020	1,097	1,143	2,484,680.53	2,308,336.90	2,901,587.07
Wexford	90	96	105	124,716.36	227,271.95	168,712.38
Detroit	1,412	1,456	1,609	3,104,611.56	3,519,551.84	5,865,362.60
Unknown	3	2	2	143.72	238.27	1,001.42

*Including only those processed through the automated payment system.

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TABLE II

EXPENDITURES* BY DIAGNOSIS GROUPS AND CONDITIONS FOR MEDICAL CARE AND TREATMENT

DIAGNOSIS GROUPS AND CONDITIONS	09/30/87 EXPENDITURES	09/30/87 CASES	09/30/88 EXPENDITURES	09/30/88 CASES	09/30/89 EXPENDITURES	09/30/89 CASES
TOTAL - ALL DIAGNOSES	**$27,876,957.41**	**15,628**	**$29,110,311.91**	**16,272**	**$34,520,194.44**	**16,551**
GROUP I - Infective and Parasitic Diseases	36,857.65	39	40,927.12	45	113,228.49	57
1. Late Effects of Poliomyelitis	14,164.05	16	7,832.85	13	13,195.02	12
2. Late Effects of Encephalitis	16,862.99	9	15,709.30	10	18,726.68	12
3. Other Infectious Diseases	5,830.61	14	17,384.97	22	81,306.79	33
GROUP II - Neoplasms	2,418,866.79	791	2,345,474.19	784	2,819,925.82	831
4. Malignant Neoplasms	1,017,835.38	305	1,072,329.35	311	1,344,966.80	342
5. Hodgkins Disease	22,760.68	29	55,912.15	32	30,257.40	40
6. Leukemia	1,076,419.05	301	853,458.63	286	1,141,467.54	296
7. Other Malignant Neoplasms	73,612.57	38	169,468.02	42	131,980.86	49
8. Benign Neoplasms	228,239.11	118	194,306.04	113	171,253.22	104
GROUP III- Endocrine, Nutritional and Metabolic Diseases	2,038,952.54	930	2,450,825.16	1,023	3,054,835.51	1,150
9. Diabetes, Juvenile	441,716.62	203	468,798.19	249	492,652.02	338
10. Nutrition Deficiency	95,037.15	13	88,716.34	12	83,071.18	12
11. Cystic Fibrosis, Under Age 21	644,616.44	322	716,052.05	319	747,014.93	324
12. Cystic Fibrosis, Age 21 and Over	389,685.03	85	391,442.19	88	379,426.66	91
13. Other Glandular and Metabolic Diseases	467,897.30	307	785,816.39	355	1,352,670.72	385
GROUP IV - Diseases of the Blood and Blood Forming Organs	1,849,865.39	380	1,816,473.28	437	3,989,162.81	456
14. Anemias	453,048.85	144	496,290.42	151	445,427.41	167
15. Hemophilia Under Age 21	576,127.84	119	466,824.29	143	2,204,027.49	132
16. Hemophilia Age 21 and Over	719,768.83	81	780,471.52	100	1,292,515.16	111
17. Other Diseases of the Blood and Blood Forming Organs	100,919.87	36	72,887.05	43	47,192.75	46
GROUP V - Mental Disorders	2,959.96	10	4,911.95	11	3,124.47	20
18. Drug Dependence	.00	0	.00	0	.00	0
19. Gilles De La Tourette's Disorder	2,959.96	10	4,911.95	11	3,124.47	20

*Including only those processed through the automated payment system

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TABLE II (continued) EXPENDITURES* BY DIAGNOSIS GROUPS AND CONDITIONS FOR MEDICAL CARE AND TREATMENT

DIAGNOSIS GROUPS AND CONDITIONS	09/30/87 EXPENDITURES	09/30/87 CASES	09/30/88 EXPENDITURES	09/30/88 CASES	09/30/89 EXPENDITURES	09/30/89 CASES
GROUP VI - Diseases of the Nervous System and Sense Organs	$5,512,962.92	5,466	$6,883,468.65	5,850	$7,367,861.10	5,974
20. Muscular Dystrophy	49,489.81	31	93,813.23	43	195,030.60	37
21. Cerebral Palsy	2,723,802.57	1,659	3,313,431.84	1,738	3,248,828.39	1,785
22. Epilepsy	435,615.72	421	551,626.19	477	703,926.51	534
23. Other Inflammatory Diseases of the Central Nervous System	781,190.84	383	1,066,280.13	423	1,263,502.83	431
24. Diseases of the Nerves and Peripheral Ganglia	148,502.09	91	369,812.79	87	283,943.70	93
25. Inflammatory Diseases of the Eye	154,311.60	369	231,518.79	438	341,639.81	458
26. Diseases of the Ear and Mastoid Process	1,220,050.29	2,512	1,256,985.68	2,644	1,330,989.26	2,636
GROUP VII - Diseases of the Circulatory System	552,954.74	206	465,466.82	212	651,667.36	221
27. Rheumatic Fever With Heart Involvement	57,086.27	19	67,701.69	24	31,332.38	20
28. Rheumatic Fever Without Heart Involvement	82.80	1	.00	0	.00	0
29. Other Heart Diseases	177,642.55	111	332,114.10	110	348,526.02	118
30. Other Diseases of the Circulatory System	318,143.12	75	65,651.03	78	271,808.96	83
GROUP VIII - Diseases of the Respiratory System	569,093.39	528	553,969.38	606	658,109.00	689
31. Asthma	528,559.45	516	482,308.60	589	524,874.67	666
32. Paralysis of the Vocal Cords or Larynx	786.66	2	46,457.39	6	80,872.90	10
33. Other Diseases of the Respiratory System	39,747.28	10	25,203.39	11	52,361.43	13
GROUP IX - Diseases of the Digestive System	640,560.14	209	323,560.72	199	442,105.84	187
34. Diseases of the Digestive System	640,560.14	209	323,560.72	199	442,105.84	187
GROUP X - Diseases of the Genitourinary System	556,503.42	221	509,036.81	237	588,094.05	259
35. Nephritis and Nephrosis	319,196.19	135	329,278.24	143	452,329.22	148
36. Other Diseases of the Genitourinary System	237,307.23	86	179,758.57	94	135,764.83	111

*Including only those processed through the automated payment system.

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TABLE II (continued) EXPENDITURES* BY DIAGNOSIS GROUPS AND CONDITIONS FOR MEDICAL CARE AND TREATMENT

DIAGNOSIS GROUPS AND CONDITIONS	09/30/87 EXPENDITURES	09/30/87 CASES	09/30/88 EXPENDITURES	09/30/88 CASES	09/30/89 EXPENDITURES	09/30/89 CASES
GROUP XII - Diseases of the Skin and Subcutaneous Tissue	$ 42,353.56	32	$ 36,924.36	35	$ 29,480.14	33
37. Diseases of the Skin and Subcutaneous Tissue	42,353.56	32	36,924.36	35	29,480.14	33
GROUP XIII - Diseases of the Musculoskeletal System and Connective Tissue	472,245.03	544	526,450.35	527	512,854.19	479
38. Arthritis and Rheumatism, except Rheumatic Fever	188,392.43	159	235,721.75	171	258,630.55	165
39. Osteomyelitis and Periostitis	766.90	1	55.00	1	781.53	2
40. Osteochondrosis	62,748.75	61	60,168.59	68	45,009.30	62
41. Other Diseases of the Bone	18,951.81	23	28,503.80	23	13,969.95	21
42. Ankylosis of Joint	.00	0	.00	0	.00	0
43. Other Diseases of Joint	8,275.19	11	19,208.91	27	19,203.64	10
44. Other Diseases of the Musculoskeletal System	8,141.11	13	.00	0	4,117.17	15
45. Curvature of the Spine	151,023.44	222	160,430.60	183	135,527.12	144
46. Other Deformities	33,945.40	54	22,361.70	54	35,614.93	60
GROUP XIV - Congenital Anomalies	9,611,290.99	4,653	9,263,388.69	4,745	9,429,960.89	4,651
47. Spina Bifida	1,399,482.30	477	1,457,108.72	494	1,460,473.94	495
48. Congenital Hydrocephalus	825,152.84	323	764,013.99	333	745,564.57	319
49. Other Congenital Anomalies of Nervous System	193,615.43	104	224,345.68	110	266,193.37	92
50. Congenital Anomalies of the Heart	1,283,877.18	695	1,935,618.54	710	2,119,799.70	696
51. Other Congenital Anomalies of Circulatory System	1,898,054.39	378	1,029,777.16	402	883,419.25	334
52. Cleft Palate	297,744.49	263	242,370.36	285	249,961.07	280
53. Cleft Lip	66,986.11	88	50,136.56	86	33,760.21	76
54. Cleft Palate with Cleft Lip	726,475.40	682	748,476.13	695	595,919.84	658
55. Club Foot, Congenital and Acquired	181,229.04	261	248,246.69	269	177,011.38	249
56. Congenital Dislocation of Hip	103,347.79	72	143,222.71	72	28,956.93	69
57. Congenital Reduction Deformity of Limb	163,281.94	169	127,536.17	152	130,293.62	132
58. Other Congenital Deformity of Upper Limb	41,765.60	33	31,408.40	35	49,408.09	27
59. Other Congenital Deformity of Lower Limb	2,546.94	9	17,122.77	12	5,884.36	15

*Including only those processed through the automated payment system.

TABLE II (continued) EXPENDITURES* BY DIAGNOSIS GROUPS AND CONDITIONS FOR MEDICAL CARE AND TREATMENT

DIAGNOSIS GROUPS AND CONDITIONS	09/30/87		09/30/88		09/30/89	
	EXPENDITURES	CASES	EXPENDITURES	CASES	EXPENDITURES	CASES
Congenital Anomalies (cont.)						
60. Other Congenital Anomalies	$2,427,731.54	1,099	$2,244,004.81	1,090	$2,683,314.56	1,209
GROUP XV - Certain Diseases Peculiar to Newborn Infants	2,116,135.21	701	2,649,498.08	890	3,974,772.68	1,043
61. Respiratory Distress Syndrome	488,175.84	171	567,354.49	138	735,926.96	163
62. Perinatal Chronic Respiratory Disorder	637,562.94	141	840,380.43	220	1,863,670.34	347
63. Other Diseases	990,396.43	389	1,241,763.16	532	1,375,175.38	533
GROUP XVI - Symptoms and Ill-Defined Conditions	948,914.69	701	616,720.06	445	243,081.14	256
64. Sudden Infant Death Syndrome	.00	0	127.93	1	.00	0
65. Deferred, Ill-Defined & Provisional	948,914.69	701	616,592.13	444	243,081.14	256
GROUP XVII - Injury and Poisoning	506,440.99	217	623,216.29	226	641,930.95	245
66. Burns	111,916.98	59	259,668.05	55	277,632.88	53
67. Fractures of Skull, Spine and Trunk	111,275.77	23	131,767.43	26	69,990.26	36
68. Fractures of Upper Limbs	356.02	2	456.97	1	1,295.19	1
69. Fractures of Lower Limbs	488.22	1	2,079.54	5	10,028.15	5
70. Dislocation Without Fracture	.00	0	.00	0	.00	0
71. Intercranial Injury Excluding Those with Skull Fracture	118,705.60	37	105,912.07	47	95,405.55	49
72. Laceration and Open Wound of Head, Neck and Trunk	5,371.69	12	14,449.46	11	29,600.11	19
73. Laceration and Open Wound of Upper Limb	5,189.78	2	15,142.28	3	1,016.05	3
74. Traumatic Amputation of Thumb, Finger(s), Arm and Hand	10,821.68	15	3,492.66	11	6,075.82	9
75. Traumatic Amputation of Toe(s), Foot or Leg(s)	82,130.41	40	65,874.06	38	66,050.18	33
76. Injury to Nerves and Spinal Cord	52,105.67	9	11,435.48	8	3,660.77	9
77. Other and Unspecified Injuries and Reactions	8,085.17	17	12,938.29	21	81,175.99	28

*Including only those processed through the automated payment system.

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TABLE III EXPENDITURES BY PROVIDER TYPE

Type of Service	9/30/87	9/30/88	9/30/89
Physician	$2,852,499	$3,199,885	$3,123,128
Hospital - Outpatient	1,672,408	1,831,679	2,256,554
Hospital - Inpatient	13,736,861	12,282,646	13,260,131
Home Care	972,768	1,392,792	2,394,185
Appliances/Braces/Durable Medical Equipment	4,326,156	5,508,630	5,554,265
Pharmacy	3,264,467	3,787,021	6,769,465
Hearing & Speech Services	917,808	958,622	949,868
Ancillary Services	133,990	149,037	212,598

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DSCC/Children's Special Health Care Services

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